SERFF Tracking Number:	*AMFA-127045247*	*State:*	*Arkansas*
Filing Company:	*Standard Insurance Company*	*State Tracking Number:*	*48048*
Company Tracking Number:	*SIC - 9040 REV. 02-11*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*SIC - 9040 Rev. 02-11*		
Project Name/Number:	*9040 Rev. 02-11/9040 Rev. 02-11*		

Filing at a Glance

Company: Standard Insurance Company

Product Name: SIC - 9040 Rev. 02-11	SERFF Tr Num: AMFA-127045247	State: Arkansas
TOI: H10G Group Health - Dental	SERFF Status: Closed-Approved-Closed	State Tr Num: 48048
Sub-TOI: H10G.000 Health - Dental	Co Tr Num: SIC - 9040 REV. 02-11	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Janis Landon, Stephanie Mundt	Disposition Date: 03/01/2011
	Date Submitted: 02/22/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: 9040 Rev. 02-11	Status of Filing in Domicile: Pending
Project Number: 9040 Rev. 02-11	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer, Association	Overall Rate Impact:
Filing Status Changed: 03/01/2011	
State Status Changed: 03/01/2011	Deemer Date:
Created By: Janis Landon	Submitted By: Janis Landon

Corresponding Filing Tracking Number:
Filing Description:
Insert Pages: 9040 Rev. 02-11 – Schedule of Benefits
Optionals and Variables

PLEASE NOTE: This filing is identical in content to two other filings being submitted on behalf of Ameritas Life Insurance Corp. and Reliance Standard Life Insurance Company. We would appreciate the Department's consideration of consistent and similar reviews.

Dear Sir/Madam:

SERFF Tracking Number:	*AMFA-127045247*	*State:*	*Arkansas*
Filing Company:	*Standard Insurance Company*	*State Tracking Number:*	*48048*
Company Tracking Number:	*SIC - 9040 REV. 02-11*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*SIC - 9040 Rev. 02-11*		
Project Name/Number:	*9040 Rev. 02-11/9040 Rev. 02-11*		

Enclosed for your review and approval is the above captioned form. This form will replace 9040 Rev. 03-08 and 9040 DR Rev. 03-09, previously approved by your Department under SERFF #'s AMFA-125485832 and AMFA-126071553. This filing allows us to reformat, clarify and combine the two forms into one. This form will be used with the group dental forms 9000 Rev. 03-08 and certificate 9021 Rev. 03-08, previously approved by the Department under SERFF# AMFA-125485832. The proposed effective date will be upon approval by your Department.

This form will be marketed to any eligible group as defined by the state of issue however; the primary market will be an employer-employee group.

We are requesting approval of this form with the variability as noted within the items bracketed and defined within the Optionals and Variables. These variable provisions reflect the plan design options and features, which are selected by the policyholder. These include varying deductibles, coinsurance percentages, maximums and claim allowance options.

This form, when scored with the policy and certificate, achieves a score of 50 when scored on the Flesch reading ease test. No part of this filing contains any unusual or possibly controversial items from normal company and industry standards.

Thank you for your review of this filing. If you need anything additional, please feel free to contact me at 800-745-1112, ext. 82444, FAX 402-309-2573 or email jlandon@ameritas.com.

Sincerely,
Janis Landon
Senior Contract Analyst

Company and Contact

Filing Contact Information

Janis Landon, Senior Contract Analyst
475 Fallbrook Blvd.
Lincoln, NE 68521

jlandon@ameritas.com
800-745-1112 [Phone] 82444 [Ext]
402-309-2573 [FAX]

Filing Company Information

Standard Insurance Company
900 SW Fifth Avenue
Portland, OR 97204-1235
(800) 745-6665 ext. [Phone]

CoCode: 69019
Group Code: -99
Group Name:
FEIN Number: 93-0242990

State of Domicile: Oregon
Company Type:
State ID Number:

SERFF Tracking Number:	*AMFA-127045247*	*State:*	*Arkansas*
Filing Company:	*Standard Insurance Company*	*State Tracking Number:*	*48048*
Company Tracking Number:	*SIC - 9040 REV. 02-11*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*SIC - 9040 Rev. 02-11*		
Project Name/Number:	*9040 Rev. 02-11/9040 Rev. 02-11*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	1 Form = $50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Insurance Company	$50.00	02/22/2011	44928126

SERFF Tracking Number:	*AMFA-127045247*	*State:*	*Arkansas*
Filing Company:	*Standard Insurance Company*	*State Tracking Number:*	*48048*
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TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*SIC - 9040 Rev. 02-11*		
Project Name/Number:	*9040 Rev. 02-11/9040 Rev. 02-11*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/01/2011	03/01/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Optionals and Variables	Janis Landon	02/23/2011	02/23/2011

SERFF Tracking Number:	*AMFA-127045247*	*State:*	*Arkansas*
Filing Company:	*Standard Insurance Company*	*State Tracking Number:*	*48048*
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Product Name:	*SIC - 9040 Rev. 02-11*		
Project Name/Number:	*9040 Rev. 02-11/9040 Rev. 02-11*		

Disposition

Disposition Date: 03/01/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMFA-127045247*	*State:*	*Arkansas*
Filing Company:	*Standard Insurance Company*	*State Tracking Number:*	*48048*
Company Tracking Number:	*SIC - 9040 REV. 02-11*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*SIC - 9040 Rev. 02-11*		
Project Name/Number:	*9040 Rev. 02-11/9040 Rev. 02-11*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document *(revised)*	Optionals and Variables	Approved-Closed	Yes
Supporting Document	Optionals and Variables	Replaced	Yes
Supporting Document	3rd Party Authorization	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes

SERFF Tracking Number:	*AMFA-127045247*	*State:*	*Arkansas*
Filing Company:	*Standard Insurance Company*	*State Tracking Number:*	*48048*
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TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*SIC - 9040 Rev. 02-11*		
Project Name/Number:	*9040 Rev. 02-11/9040 Rev. 02-11*		

Amendment Letter

Submitted Date: 02/23/2011

Comments:

We have attached a corrected Optionals and Variables.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Optionals and Variables

Comment:

Opt & Var 9040 Rev. 02-11.pdf

SERFF Tracking Number:	*AMFA-127045247*	*State:*	*Arkansas*
Filing Company:	*Standard Insurance Company*	*State Tracking Number:*	*48048*
Company Tracking Number:	*SIC - 9040 REV. 02-11*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*SIC - 9040 Rev. 02-11*		
Project Name/Number:	*9040 Rev. 02-11/9040 Rev. 02-11*		

Form Schedule

Lead Form Number: 9040 Rev. 02-11

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/01/2011	9040 Rev. 02-11	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Schedule of Benefits	Revised	Replaced Form #: 9040 Rev. 03-08 Previous Filing #: AMFA-125485832	50.000	9040 Rev. 02-11-ppo.pdf

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured [and each Insured Dependent] will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
[Class 1	All Eligible Employees]

[DENTAL EXPENSE BENEFITS
[When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out-of-pocket costs.]

Deductible Amount:

[When a Participating Provider is used:]

[Type 1 Procedures] - [each Benefit Period]	[$0][*]
[Type 2 Procedures] - [each Benefit Period]	[$50][*]
[Type 3 Procedures] - [each Benefit Period]	[$50][*]
[Type 4 Procedures] - [each Benefit Period]	[$50][*]

[When a Non-Participating Provider is used:]

[Type 1 Procedures] - [each Benefit Period]	[$0][*]
[Type 2 Procedures] - [each Benefit Period]	[$50][*]
[Type 3 Procedures] - [each Benefit Period]	[$50][*]
[Type 4 Procedures] - [each Benefit Period]	[$50][*]

Maximum Deductible [each Benefit Period, per Quarter] [$50]

[[Any deductible satisfied during the Benefit Period will be applied to both the Participating Provider Deductible and the Non-Participating Provider Deductible.] Once the Maximum Deductible per Benefit Period has been met, no further deductible will be required for that Benefit Period.]

[Dental expenses incurred by an individual on or after January 1, [2010], but before [May 1, 2010], will apply to the Deductible Amount if:

a. proof is furnished to us that such dental expenses were applicable to the deductible under the Policyholder's dental insurance policy in force immediately prior to [May 1, 2010]; and

b. such expenses would have been considered Covered Expenses under this policy had this policy been in force at the time the expenses were incurred.]

Coinsurance Percentage:	[Participating Provider]	[Non-Participating Provider]
[Type 1 Procedures]	[100%]	[90%]
[Type 2 Procedures]	[80%]	[70%]
[Type 3 Procedures]	[50%]	[40%]
[Type 4 Procedures]	[50%]	[50%]

Maximum Amount – [Each Benefit Period] [$1500][*]

SCHEDULE OF BENEFITS
(Continued)

[***You and/or your dependents must be insured under the dental plan for*** [***6***] ***months to be eligible for Type*** [***3***] ***Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.]]***

[**ORTHODONTIC EXPENSE BENEFITS**

[Deductible Amount]	[$0]
[Coinsurance Percentage]	[50%]
[Maximum Benefit during Lifetime]	[$1,000]]

[The Plan pays [25%-50%] of covered Orthodontic Expenses.]

[The Maximum Benefit shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on [December 31, 2007], and
b. on [January 1, 2008] is both:
   i. insured under the policy, and
   ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

a. the normal benefit payable under the policy for the current Treatment Program, minus any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.]

[***You and/or your dependents must be insured under the dental plan for*** [***12***] ***months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.***]]

[**EYE CARE EXPENSE BENEFITS**

[When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out-of-pocket costs.]

Deductible Amount:

[Exam- [each Benefit Period]]	[$ 10][*]
[Lenses - Other than contact lenses- [Once Per Lifetime]]	[$ 25][*]
[Frames and Contact Lenses - [Once Per Lifetime]	[$ 25][*]

[Maximum Amount – [each Benefit Period] [$200][*]

[***Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.]***]
[**LASER VISION CORRECTION EXPENSE BENEFITS**

[Deductible Amount - [each Benefit Period]]	$[50]
Coinsurance Percentage:	[100%]

[***Please refer to the LASER VISION CORRECTION BENEFIT RIDER for details regarding frequency, limitations, and exclusions.***]]

[**HEARING CARE EXPENSE BENEFITS**

Deductible Amount:

[Exams] - [each Benefit Period]	[$0]
[Hearing Aids] - [each Benefit Period]	[$0]
[Hearing Aid Maintenance] - [each Benefit Period]	[$0]
[Hearing Miscellaneous] - [each Benefit Period]	[$0]]

[If an Insured incurs Covered Expenses:

i. during the last three months of any Benefit Period; and
ii. these expenses are applied towards the Deductible Amount for that Benefit Period,

Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.]

Coinsurance Percentage:

[Exams]	[100%*]
[Hearing Aids]	[50%]
[Hearing Aid Maintenance]	[100%*]
[Hearing Miscellaneous]	[100%*]]

*refer to 9290 SCHEDULE OF HEARING CARE SERVICES regarding the amount of benefits payable.

[[Hearing Aid] Maximum Amount [(per ear)]:	
[1st 12 month Period]	$[400]
[2nd 12 month Period]	$[600]
[3rd 12 month Period]	$[800]
[4th 12 month Period or thereafter]	$[1,000]

The term “12 Month Period” means the 12 month period of time beginning with the effective date of the hearing care benefits shown above for the Insured and each Insured Dependent, if any, and thereafter each subsequent 12 month period that begins on the anniversary of the effective dates described earlier in this sentence. It is important to note that for purposes of determining the appropriate 12 Month Period, the Insured and each Insured Member, if any, may have different initial effective dates depending on when they first became covered by this Policy.

EXCEPTION: If an Insured or Insured Dependent, if any, was previously covered under this policy but had a break in continuous coverage under this policy of more than twelve consecutive months, upon resuming coverage hereunder the Insured or Insured Dependent, if any, will be considered a new insured person for determining the applicable 12 Month Period when calculating the Covered Expense. After

resuming coverage under this policy following a break in coverage of more than 12 consecutive months, the insured's initial 12 Month Period (and each subsequent 12 Month Period) will be based on the Insured's new effective date. Insureds with a break in coverage under this policy of less than 12 consecutive months will, upon resumption of their coverage under this policy, be treated as if they had continuous coverage under this policy BUT ONLY FOR PURPOSES OF THE 12 MONTH PERIOD DETERMINATION. For all other purposes, persons will not be considered insured under this policy during any period of time when their coverage is not in effect.]

[COMBINED EXPENSE BENEFITS

[*Combined [Dental And Eye Care] Deductible Amount: [each Benefit Period]] [$50]
The deductibles listed with the (*) above are subject to the maximum deductible amount listed here.]

[*Combined [Dental and Eye Care] Maximum – [each Benefit Period] [$1,500]
The maximums listed with the (*) above are subject to the maximum amount listed here.]

[Combined [Dental and Eye Care] Exam Frequencies
Routine Exams for [Dental and Eye Care] are limited to [Twice] per [Benefit Period]

Dental Exams will include:
[D0120 Periodic oral evaluation]
[D0150 Comprehensive oral evaluation - new or established patient.]
[D0180 Comprehensive periodontal evaluation – new or established patient.]

A routine eye care exam is a vision examination as defined on the Schedule of Eye Care Services.]

The above frequencies for [Dental and Eye Care] Exams are subject to the plan frequencies as defined within the [Table of Dental Procedures and the Eye Care Insurance provision].]]

[**DENTAL EXPENSE BENEFITS**
[When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.]

First Level:	The Plan pays [0 - 100]% of the first $[0-5,000] of Covered [Preventive, Dental and Orthodontic] Expenses [up to the Maximum Amount].
Second Level:	You pay the next $[25 - 250] of Covered Expenses. (You will not be reimbursed for this $[25 - 250] of Covered Expenses.)
Third Level:	The Plan will also pay [0 - 100]% of the next $[0 - 5,000] of any Covered [Dental and Orthodontic] Expenses [subject to the Maximum Amount].
Fourth Level:	The Plan will also pay [0 - 100]% of the next $[0 - 5,000] of any Covered [Dental and Orthodontic] Expenses [subject to the Maximum Amount].
Fifth Level:	The Plan will also pay [0 - 100]% of the remaining $[0 - 5,000] of any Covered [Dental and Orthodontic] Expenses [subject to the Maximum Amount].

[Maximum Amount [per Benefit Period] $[500 - 2,500, Not Applicable]]

SERFF Tracking Number:	*AMFA-127045247*	*State:*	*Arkansas*
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Product Name:	*SIC - 9040 Rev. 02-11*		
Project Name/Number:	*9040 Rev. 02-11/9040 Rev. 02-11*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	03/01/2011

Comments:

Attachment:

ar-readability-sic.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	03/01/2011

Bypass Reason: n/a

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Optionals and Variables	Approved-Closed	03/01/2011

Comments:

Attachment:

Opt & Var 9040 Rev. 02-11.pdf

		Item Status:	Status Date:
Satisfied - Item:	3rd Party Authorization	Approved-Closed	03/01/2011

Comments:

Attachment:

SIC authorization 08-2010.pdf

STATE OF ARKANSAS

CERTIFICATE OF READABILITY

INSURER: Standard Insurance Company

This is to certify that the attached form(s) has achieved a Flesch Reading Ease Score of:

FORM NO:	FLESCH SCORE:	FORM NAME:
9040 Rev. 02-11	50, with policy/certificate	Schedule of Benefits

complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

SIGNATURE: Gail M. Garcia

Digitally signed by Gail M. Garcia
DN: cn=Gail M. Garcia, o=Ameritas Life Insurance Corp., ou=Group Compliance, email=ggarcia@ameritas.com, c=US
Date: 2010.09.01 12:41:24 -05'00'

TYPED NAME: Gail M. Garcia
TITLE: Vice President - Group Compliance

DATE: 02/22/2011

OPTIONALS AND VARIABLES
9040 Rev. 02-11

No change will be made to any policy or certificate in violation of state statutes.

General Items

1) We wish to reserve the right to change any addresses, telephone number, websites, and titles of company personnel should they change in the future.

2) If the Policyholder has elected multiple plan designs which may be offered within the same policy, e.g., different plans per classes of insureds, optional buy-up feature, tec., then the group policy will be issued with multiple Schedule of Benefits (9040), Dental Expense Benefits (9219) and Table of Dental Procedures (9232) which will reflect each plan design being offered. Each certificate will include on those pages reflecting that plan design.

3) If the Policyholder does not choose to cover Dependents, all Dependent provisions and references will be deleted.

4) References to Dental, Eye Care and/or Hearing will be added/removed if the plan design does not contain Dental, Eye Care, and/or Hearing as selected by the Policyholder.

5) References to Employer and Employee and the subsequent sections that pertain to an Employer/Employee relationship under the policy may be removed if issued to a policy that is not sponsored by an employer.

SCHEDULE OF BENEFITS – 9040

The Benefit Class Description of eligible members and dependents could be modified as required by the policyholder.

The sample Schedule of Benefits pages as submitted illustrates one specific plan design. The following illustrate the variances, which are based on the plan design selected by the Policyholder. The Schedule of Benefits will reflect the plan design chosen by the Policyholder.

If a particular Benefit Type is not selected by the Policyholder or not included because of coverage philosophy that Benefit Type will be removed entirely.

BENEFIT CLASS & OPTIONS

1. References to certain benefits, (ex. orthodontia, eye care, ppo), could be deleted if not selected by the Policyholder. Benefit options such as deductibles, coinsurance percentages and maximums will reflect the plan design selected by the Policyholder.

2. All benefits, definitions, waiting periods and contributions could be broken out to provide different levels according to classes if required by the Policyholder. (ex. Union employees, non-union employees, clerical employees, non-clerical employees).

DENTAL EXPENSE BENEFITS

When the Policyholder has not chosen a PPO (or Participating Provider) option, all references to participating and non-participating providers are deleted.

DEDUCTIBLE AMOUNT

Dependent upon Policyholder selection, Deductible Amounts can range from $0 to $250 in increments of $5, by frequency of services and/or Benefit Type, and can be applied per Benefit Period, Quarter, Visit,and/or Lifetime. Deductible Amounts can be combined to apply to more than one Benefit Type. For example, a $50 per Benefit Period deductible can apply to Type 1, Type 2, Type 3, and/or Type 4 benefits.

If the Deductible Amount is different when utilizing a Participating Provider versus a Non-Participating Provider the Deductible Amount will be listed similar to the following:

Deductible Amount:

When a Participating Provider is used:
Combined Type 1, 2 and Type 3 Procedures - each Benefit Period
$50

When a Non-Participating Provider is used:
Type 1 Procedures
$0
Combined Type 2 and Type 3 Procedures - each Benefit Period
$50

The Maximum Deductible option provides a limit on the Deductible amounts that apply in a Benefit Period. For example, a $10 per Visit Deductible when seeing a Participating Provider and a $50 per Benefit Period Deductible when seeing a Non-Participating Provider may be limited to a total of $50 per Benefit Period deductible when a Participating and Non-Participating Provider are seen in the same Benefit Period. The following language would be added for plans with this option:

Maximum Deductible per Benefit Period
$50

Any deductible satisfied during the Benefit Period will be applied to both the Participating Provider Deductible and the Non-Participating Provider Deductible. Once the Maximum Deductible per Benefit Period has been met, no further deductible will be required for that Benefit Period.

When the policyholder has chosen to include a deductible carry-over provision, the following language will be added to the paragraph DEDUCTIBLE AMOUNT, on the Schedule of Benefits:

If an Insured incurs Covered Expenses:

i. during the last three months of any Benefit Period; and

ii. these expenses are applied towards the Deductible Amount for that Benefit Period,

Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.

When the policyholder has chosen to include a maximum on the number of Deductibles required to be satisfied by a family, the following language will be added to the paragraph DEDUCTIBLE AMOUNT or added by rider:

On the date that [two] [three] [four] members of one family have satisfied their own Deductible Amounts for [the Benefit Period] [their Lifetime], no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that [Benefit Period]. No Covered Expense that was incurred prior to such date that was used to satisfy any part of a Deductible Amount will be eligible for reimbursement, however.

When the policyholder has chosen to include a maximum dollar amount of deductible required to be satisfied by a family, the following language will be added to the paragraph DEDUCTIBLE AMOUNT or added by rider. This dollar amount may be per Benefit Period, Quarter, or Lifetime and ranges from $0 - $300 in $5 increments.

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that [Benefit Period] [Quarter] [their Lifetime].

Maximum Family Deductible
$[150]

When the policyholder has chosen to include a maximum dollar amount of Deductible required to be satisfied by a family with different amounts when choosing a Participating versus Non-Participating Provider, the following language will be added to the paragraph DEDUCTIBLE AMOUNT or added by rider. The dollar amounts may be by Benefit Period, Quarter, or per Lifetime and range from $0 - $300 in $5 increments:

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that [Benefit Period] [Quarter] [their Lifetime].

	Participating Provider	Non-Participating Provider
Maximum Family Deductible	$[100]	$[150]

The paragraph regarding Deductible Takeover will be removed if the plan design selected does not include benefits for Takeover.

COINSURANCE PERCENTAGE

The Coinsurance Percentage can range between 0% to 100% in increments of 5%.

Type 1 Procedures	25% - 100%
Type 2, 3, or 4 Procedures	0% - 100%

If the Plan Allowance selected by the policyholder is on a scheduled basis or is based solely on the Actual Charge of the provider the following is included next to the Coinsurance Percentage for clarification purposes:

Coinsurance Percentage:

Type 1 Procedures	25% - 100% [of Schedule, of Actual Charges]
Type 2 Procedures	0% - 100% [of Schedule, of Actual Charges]
Type 3 Procedures	0% - 100% [of Schedule, of Actual Charges]

Type 4 Procedures 0% - 100% [of Schedule, of Actual Charges]

If the Coinsurance Percentage is different when utilizing a Participating Provider versus a Non-Participating Provider the Coinsurance Percentage will be as listed in the example below:

Coinsurance Percentage:	Participating Provider	Non-Participating Provider
[Type 1 Procedures]	[25% - 100%]	[25% - 100%]
[Type 2 Procedures]	[0% - 100%]	[0% - 100%]
[Type 3 Procedures]	[0% - 100%]	[0% - 100%]
[Type 4 Procedures]	[0% - 100]	[0% - 100%]

The difference between participating and non-participating providers will not exceed state allowances.

If an Incentive Coinsurance Percentage is selected it will be as listed in the **example** below. The Incentive Coinsurance Percentage amounts will also vary from 0% - 100% in increments of 5%. It may also be separated into Participating Provider versus Non-Participating Provider amounts, similar to the above, if the Coinsurance Percentage is different when utilizing a Participating Provider versus Non-Participating Provider and determined on an Incentive basis.

Coinsurance Percentage:	
Type 1 Procedures:	
Step 1.	70%
Step 2.	80%
Step 3.	90%
Step 4.	100%
Type 2 Procedures:	
Step 1.	50%
Step 2.	60%
Step 3.	80%
Step 4.	90%
Type 3 and Type 4 Procedures:	
Step 1.	25%
Step 2.	35%
Step 3.	50%
Step 4.	60%

If an Incentive Coinsurance Percentage is selected, a descriptive paragraph outlining when the Insured moves between the Steps will be included. The Coinsurance Steps range from two steps up to four steps. The Coinsurance Percentage as listed will be adjusted to accurately reflect the number of steps included in the plan design. The dates used below are illustrative, the appropriate dates based on the policyholder's actual effective date will be used. Below are the Incentive Method descriptive paragraph options that can be selected:

1. Effective Date Incentive:

[For those persons insured on [January 1, 2009] Step [3] applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person fails to visit a dentist or fails to have a dental procedure performed, Step 1 will automatically reapply during the following Benefit Period, and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

2. Date of Hire Incentive:

A. The Coinsurance Percentage Steps for those persons insured after [January 1, 2009], will be determined as follows:

1. Step 1 applies during the first Benefit Period the person becomes insured.

2. If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 and 3 will apply during the second and third Benefit Period, respectively, and Step 4 will apply during each Benefit Period after.

3. If, during any Benefit Period, the person fails to visit a dentist to have a dental procedure performed, Step 1 will automatically reapply during the following Benefit Period, and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

   Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

B. The Coinsurance Percentage Steps for those persons insured on [January 1, 2009], will be determined as follows:

Step 1 Those employed in [2009].

Step 2 Those employed in [2008].

Step 3 Those employed in [2007].

Step 4 Those employed prior to [2007].

1. Any such person between [January 1, 2009], and [December 31, 2009] will advance to the next higher Coinsurance Percentage Step on January 1, [2010].

2. Any person falling in #1 above who does not visit a dentist during [2010] and have a dental procedure performed, will revert to Step 1 on January 1, [2011]

3. Any person who has advanced to the next higher Coinsurance Percentage Step will advance to the next higher step if during each Benefit Period, he or she

visits a dentist and has a dental procedure performed. If this is not done, however, the person will revert to Step 1 on the next following January 1 and must advance to Steps 2, 3 and 4 as if he or she were newly insured.

3. Progressive Incentive:

[For those persons insured on [January 1, 2009] Step [2] applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

4. New Date of Hire Incentive:

A. The Coinsurance Percentage Steps for those persons insured after [January 1, 2009], will be determined as follows:

1. Step 1 applies during the first Benefit Period the person becomes insured.

2. If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 and 3 will apply during the second and third Benefit Period, respectively, and Step 4 will apply during each Benefit Period after.

3. If, during any Benefit Period, the person fails to visit a dentist to have a dental procedure performed, Step 1 will automatically reapply during the following Benefit Period, and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

B. The Coinsurance Percentage Steps for those persons insured on [January 1, 2009], will be determined as follows:

Step 1 Those employed in [2009].

Step 2 Those employed in [2008].

Step 3 Those employed in [2007].

Step 4 Those employed prior to [2007].

1. Any such person between [January 1, 2009], and [December 31, 2009] who does not visit a dentist during [2009] will remain at the same Step that applied during [2009].

2. Any person who has advanced to the next higher Coinsurance Percentage Step will advance to the next higher step if during each Benefit Period, he or she visits a dentist and has a dental procedure performed. If this is not done, however, the person will revert to Step 1 on the next following January 1 and must advance to Steps 2, 3 and 4 as if he or she were newly insured.

5. Family Progressive Incentive:

[For those persons insured on [January 1, 2009] Step [3] applies during the first Benefit Period.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period.

or

Step 1 applies during the first Benefit Period.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

Step 2 will apply during the second Benefit Period.

Step 3 will apply during the third Benefit Period.

Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

6. 10% Advance Incentive:

[For those persons insured on <MDY(cDivEffDate)> Step <nDenStart> applies during the first Benefit Period the person becomes insured.

For those persons insured after <MDY(cDivEffDate)> Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person fails to visit a dentist or fails to have a dental procedure performed, the coinsurance percentage drops back one Step. The coinsurance percentage will never be less than the coinsurance percentage in Step 1.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

7. Date of Hire progressive Incentive:

A. The Coinsurance Percentage Steps for those persons insured after [January 1, 2009], will be determined as follows:

1. Step 1 applies during the first Benefit Period the person becomes insured.

2. If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 and 3 will apply during the second and third Benefit Period, respectively, and Step 4 will apply during each Benefit Period after.

3. If, during any Benefit Period, the person fails to visit a dentist to have a dental procedure performed, the person will remain at the same Step that applied during the previous Benefit Period.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

B. The Coinsurance Percentage Steps for those persons insured on [January 1, 2009], will be determined as follows:

Step 1 Those employed in [2009].

Step 2 Those employed in [2008].

Step 3 Those employed in [2007].

Step 4 Those employed prior to [2007].

1. Any such person between [January 1, 2009], and [December 31, 2009] will advance to the next higher Coinsurance Percentage Step on January 1, [2010].

2. Any person falling in #1 above who does not visit a dentist during [2010] and have a dental procedure performed, will remain at the same Step that applied during the previous Benefit Period.

3. Any person who has advanced to the next higher Coinsurance Percentage Step will advance to the next higher step if during each Benefit Period, he or she visits a dentist and has a dental procedure performed. If this is not done, however, the person will remain at the same Step that applied during the previous Benefit Period.

8. Date of Hire Advance Incentive:

A. The Coinsurance Percentage Steps for those persons insured after [January 1, 2009], will be determined as follows:

1. Step 1 applies during the first Benefit Period the person becomes insured.

2. If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 and 3 will apply during the second and third Benefit Period,

respectively, and Step 4 will apply during each Benefit Period after.

3. If, during any Benefit Period, the person fails to visit a dentist to have a dental procedure performed, the insured person's coinsurance level will drop back one coinsurance level step.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than twelve months, the insured person's coinsurance level will revert back one coinsurance level step for every 12 months of the break.

B. The Coinsurance Percentage Steps for those persons insured on [January 1, 2009], will be determined as follows:

Step 1 Those employed in [2009]

Step 2 Those employed in [2008]

Step 3 Those employed in [2007]

Step 4 Those employed prior to [2007]

1. Any such person insured between [January 1, 2009], and [December 31, 2009] will advance one step to the next higher Coinsurance Percentage Step on [January 1, 2010], if they have visited a dentist and had a dental procedure performed. Initial insured employees and dependents will remain at the same coinsurance level step during [2010] if they fail to visit the dentist and have one dental procedure performed.

2. For every January 1, thereafter, should any person fail to visit the dentist in any calendar year, or should he or she fail to have at least one dental procedure performed within the given year, the person will drop back one coinsurance level step, but never below the original Step 1 coinsurance level.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than twelve months, the insured person's coinsurance level will revert back one coinsurance level step for every 12 months of the break.

MAXIMUM AMOUNT

The Maximum Amount can range between $250 to $10,000 or more in increments of $50 dependent upon plan selection.

If the Maximum Amount is different when utilizing a Participating Provider versus a Non-Participating Provider the Maximum Amount will be listed as following:

When a Non-Participating Provider is used:
Maximum Amount - Each Benefit Period
$[1,000]

When a Participating Provider is used:
Maximum Amount - Each Benefit Period
$[1,250]

If certain procedures will not count toward the Maximum Amount, a sentence such as the following will be added to the paragraph MAXIMUM AMOUNT:

In no event will expenses incurred for Type [1] Procedures count toward the Maximum Benefit.

If an Internal Maximum is selected the following text will be used. This could apply to any of the Benefit Types or may apply to procedures for Temporomandibular Joint Dysfunction. The dollar amount listed will vary based on plan selection. This Internal Maximum may apply each "Benefit Period" or "per Lifetime".

Type [3] Eligible Dental Expense Benefits may not exceed [$500] [per Lifetime, in any Benefit Period].

ELIMINATION (WAITING) PERIODS

Elimination Periods may be included based on plan selection. If included, the Elimination Period will be one of the following 3, 6, 9, 12, 18, or 24 months. The Elimination period may also apply to different Benefit Types and/or multiple Benefit Types. For example the Elimination Period could be 6 months on Type 2 Procedures and 12 months on Type 3 Procedures. If no Elimination Period applies, the entire paragraph will be removed.

ORTHODONTIC EXPENSE BENEFITS

The Orthodontic Maximum Amount can range between $250 to $10,000 or more in increments of $50 dependent upon plan selection.

The Maximum Amount for Orthodontic Expense Benefits can be applied "During Lifetime" or "each Benefit Period" or both.

If the Deductible Amount, Coinsurance, or Maximum Amount for Orthodontic expense benefits is different when utilizing a Participating Provider versus a Non-Participating Provider these amounts will be listed similar to the following:

	Participating Provider	Non-Participating Provider
Deductible Amount - Once per lifetime	$100	$150
Coinsurance Percentage	60%	50%
Maximum Benefit During Lifetime	$1,500	$1,000

An Elimination Period for Orthodontic Expense Benefits may be included based on plan selection. If included the Elimination Period will be 12, 18, or 24 months.

If the policyholder has selected a plan with Takeover for Orthodontic Expense Benefits, the following will be listed:

The Maximum Benefit shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on [January 1, 2009], and
b. on [January 1, 2009] is both:

    i. insured under the policy, and

    ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained

in force.

The modification will result in a reduction of the Maximum Benefit based on:

a. the normal benefit payable under the policy for the current Treatment Program, minus

b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.

Similar to the Dental Maximum Amount, if an internal maximum on Orthodontic Expense Benefits exists the following will be included:

Orthodontic Expense Benefits may not exceed $[1,000] [in any Benefit Period, per Lifetime].

If the Policyholder has selected a plan in which the deductible for Dental and Orthodontic Expense Benefits are combined together so that the member only has to satisfy one deductible, the following will be included:

[1] The deductible is combined for both the Dental Expense and the Orthodontic Expense Benefits.

EYE CARE EXPENSE BENEFITS

When the Policyholder has not chosen a PPO (or Participating Provider) option, all references to participating and non-participating providers are deleted.

The Deductible Amount for Eye Care Expense Benefits can range from $0 to $25 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime". The Deductible Amount may also be applied to any and/or multiple Eye Care Benefits. For Example a $25 Deductible on Lenses and Frames - Each Benefit Period. The deductible may also vary whether a Participating Provider or Non-Participating Providers is used.

The Maximum Amount for Eye Care Expense Benefits can range from $50 to $300 in $50 increments or may be removed entirely if not included in the selected plan design.

Some services such as eye care exams, frames, or lenses may not apply to the Eye Care Maximum. If the policyholder has selected this plan than the following will be included:

[Eye Care Exams] are not subject to the Eye Care Maximum Amount.

LASER VISION CORRECTION EXPENSE BENEFITS

The Deductible Amount for Laser Vision Correction Expense Benefits can range from $0 to $250 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime".

The Coinsurance Percentage for Laser Vision Correction Expense Benefits can range from 50% - 100% in 5% increments. Normally it remains at 100%. Similarly to the Dental Expense Benefits Coinsurance Percentage the Percentage can be on an incentive basis starting at 50% and increasing to as much as 100% over 2 - 4 years.

If the Incentive Coinsurance option is selected by the policyholder the following will also be included:

> [For those persons insured on [January 1, 2009] Step [2] applies during the first Benefit Period the person becomes insured.
>
> For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.
>
> or
>
> Step 1 applies during the first Benefit Period the person becomes insured.]
>
> *If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.*
>
> Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.
>
> If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

HEARING CARE EXPENSE BENEFITS

Deductible Amounts for Hearing Expense Benefits can range between $0 to $250 in increments of $5 dependent upon Policyholder selection. Deductible Amounts can be applied by Benefit Period, Quarter, Annually, per Visit, and per Lifetime. Deductible Amounts can also be combined to apply to more than one Hearing Benefit Type. For Example, a $50 per Benefit Period deductible can apply to Hearing Exams, Hearing Aids, and Hearing Aid Maintenance. The Deductible Amount listed on the Schedule of Benefits page is indicative of one of the most popular plan designs.

When the policyholder has chosen to include a deductible carry-over provision on hearing expense benefits, the following language will be added to the paragraph DEDUCTIBLE AMOUNT, on the Schedule of Benefits:

> If an Insured incurs Covered Expenses:
>
> i. during the last <u>three</u> months of any Benefit Period; and
>
> ii. these expenses are applied towards the Deductible Amount for that Benefit Period,
>
> Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.

The Coinsurance Percentage for Hearing Expense Benefits can range from 50% to 100% based on Policyholder selection and our own coverage philosophy.

The Hearing Aid Maximum Amount can apply to "both ears" or "per ear". It may increase from as little as 2 12-month periods up to 4 12-month periods. The dollar amounts can range from $400 - $1,500 dollars in $50 increments.

COMBINED EXPENSE BENEFITS

The Deductible Amount for Combined Expense Benefits, if selected by the policyholder, can range from $10 to $250 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime".

In addition, an aggregate deductible amount may be included per lifetime. This would be a deductible amount limit that an Insured would satisfy once per lifetime then no other deductible would be required. If selected by the policyholder, the following would be included:

*Combined Dental and Eye Care Deductible Amount $200
Once per Lifetime
The combined [Annual, Lifetime] deductible is subject to the Aggregate Lifetime deductible amount listed here.

The Combined Maximum Amount, if selected by the policyholder, can range from $250 to $10,000 or more in increments of $50 based on plan selection.

The Combined Exam Frequencies, if selected by the policyholder, can range from 1 to 4 Exams - Each Benefit Period or a rolling period of months based on plan selection. If applicable, the rolling number of months may be 6 months or 12 months.

The procedures listed may be changed to match the procedures listed on the 9232 Table of Dental Procedures that qualify as Dental Exams.

January 2010

TO ALL STATE INSURANCE DEPARTMENT PERSONNEL

Standard Insurance Company, Administrative Offices at 1100 SW Sixth Avenue, Portland, Oregon 97204-1093, has provided Ameritas Life Insurance Corp. with the authority to submit forms related to dental and vision insurance benefits on our behalf. Accordingly, Ameritas Life Insurance Corp. has the authority to represent us in the submission and negotiation of the approval of these forms and their accompanying rates.

In this regard, the signatures of:

Gail M. Garcia
Vice President, Group Compliance

Kelly Wieseler
Vice President, Group Actuary

Janis Landon
Senior Contract Analyst

Kate McCown
Manager, Group Compliance

Geri L. McKeown
Manager, Group Compliance

When affixed to a letter or certification of intent, will be as binding as if signed by an officer of Standard Insurance Company.

Sincerely,

Alex Terry, FSA, MAAA
Second Vice President and Associate Actuary
900 SW Fifth Avenue
Portland OR 97204-1235
971.321.8232

SERFF Tracking Number:	*AMFA-127045247*	*State:*	*Arkansas*
Filing Company:	*Standard Insurance Company*	*State Tracking Number:*	*48048*
Company Tracking Number:	*SIC - 9040 REV. 02-11*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*SIC - 9040 Rev. 02-11*		
Project Name/Number:	*9040 Rev. 02-11/9040 Rev. 02-11*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
02/21/2011	Supporting Document	Optionals and Variables	02/23/2011	Opt & Var -01-2011.pdf (Superceded)

OPTIONALS AND VARIABLES

No change will be made to any policy or certificate in violation of state statutes.

General Items

1) We wish to reserve the right to change any addresses, telephone number, websites, and titles of company personnel should they change in the future.

2) If the Policyholder has elected multiple plan designs which may be offered within the same policy, e.g., different plans per classes of insureds, optional buy-up feature, tec., then the group policy will be issued with multiple Schedule of Benefits (9040), Dental Expense Benefits (9219) and Table of Dental Procedures (9232) which will reflect each plan design being offered. Each certificate will include on those pages reflecting that plan design.

3) If the Policyholder does not choose to cover Dependents, all Dependent provisions and references will be deleted.

4) References to Dental, Eye Care and/or Hearing will be added/removed if the plan design does not contain Dental, Eye Care, and/or Hearing as selected by the Policyholder.

5) References to Employer and Employee and the subsequent sections that pertain to an Employer/Employee relationship under the policy may be removed if issued to a policy that is not sponsored by an employer.

POLICY COVER PAGE – 9000

All information, including dates, will be completed to reflect the Policyholder and policy information.

The policy description will indicate whether coverage is for “Dental"," Eye Care”, and/or "Hearing Care" Insurance.

Officer signatures and names - The names and signatures of the officers may be amended as necessary to reflect changes in company officers.

CERTIFICATE COVER PAGE – 9021

All information, including dates, will be completed to reflect the Policyholder and policy information.

The certificate description will indicate whether coverage is for “Dental" or “Dental and Eye Care”, Insurance.

Based upon Policyholder request, the certificate can be issued to a specific group as either a "named" or non-named" certificate. If issued "no-named", then the right hand column of "john Doe" information will not be displayed.

Based upon Policyholder request, the certificate can be issued along with ERISA disclosure statements in order for the Policyholder to meet ERISA Summary Plan Description (SPD) requirements.

Officer signatures and names - The names and signatures of the officers may be amended as necessary to reflect changes in company officers.

TABLE OF CONTENTS PAGE – 9035

This table will be amended to add or delete references to specific benefits based upon Policyholder selection, e.g., dental with eye care, orthodontic expense benefits, etc.

Section Numbers listed are not intended to be page numbers but rather a reference for the Policyholder to locate appropriate plan provisions. These numbers are listed on the bottom, left hand side of each section.

SCHEDULE OF BENEFITS – 9040

The Benefit Class Description of eligible members and dependents could be modified as required by the policyholder.

The sample Schedule of Benefits pages as submitted illustrates one specific plan design. The following illustrate the variances, which are based on the plan design selected by the Policyholder. The Schedule of Benefits will reflect the plan design chosen by the Policyholder.

If a particular Benefit Type is not selected by the Policyholder or not included because of coverage philosophy that Benefit Type will be removed entirely.

BENEFIT CLASS & OPTIONS

1. References to certain benefits, (ex. orthodontia, eye care, ppo), could be deleted if not selected by the Policyholder. Benefit options such as deductibles, coinsurance percentages and maximums will reflect the plan design selected by the Policyholder.

2. All benefits, definitions, waiting periods and contributions could be broken out to provide different levels according to classes if required by the Policyholder. (ex. Union employees, non-union employees, clerical employees, non-clerical employees).

DENTAL EXPENSE BENEFITS

When the Policyholder has not chosen a PPO (or Participating Provider) option, all references to participating and non-participating providers are deleted.

DEDUCTIBLE AMOUNT

Dependent upon Policyholder selection, Deductible Amounts can range from $0 to $250 in increments of $5, by frequency of services and/or Benefit Type, and can be applied per Benefit Period, Quarter, Visit,and/or Lifetime. Deductible Amounts can be combined to apply to more than one Benefit Type. For example, a $50 per Benefit Period deductible can apply to Type 1, Type 2, Type 3, and/or Type 4 benefits.

If the Deductible Amount is different when utilizing a Participating Provider versus a Non-Participating Provider the Deductible Amount will be listed similar to the following:

Deductible Amount:

When a Participating Provider is used:	
Combined Type 1, 2 and Type 3 Procedures - each Benefit Period	$50
When a Non-Participating Provider is used:	
Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - each Benefit Period	$50

The Maximum Deductible option provides a limit on the Deductible amounts that apply in a Benefit Period. For example, a $10 per Visit Deductible when seeing a Participating Provider and a $50 per

Benefit Period Deductible when seeing a Non-Participating Provider may be limited to a total of $50 per Benefit Period deductible when a Participating and Non-Participating Provider are seen in the same Benefit Period. The following language would be added for plans with this option:

Maximum Deductible per Benefit Period $50

Any deductible satisfied during the Benefit Period will be applied to both the Participating Provider Deductible and the Non-Participating Provider Deductible. Once the Maximum Deductible per Benefit Period has been met, no further deductible will be required for that Benefit Period.

When the policyholder has chosen to include a deductible carry-over provision, the following language will be added to the paragraph DEDUCTIBLE AMOUNT, on the Schedule of Benefits:

If an Insured incurs Covered Expenses:

i. during the last three months of any Benefit Period; and

ii. these expenses are applied towards the Deductible Amount for that Benefit Period,

Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.

When the policyholder has chosen to include a maximum on the number of Deductibles required to be satisfied by a family, the following language will be added to the paragraph DEDUCTIBLE AMOUNT or added by rider:

On the date that [two] [three] [four] members of one family have satisfied their own Deductible Amounts for [the Benefit Period] [their Lifetime], no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that [Benefit Period]. No Covered Expense that was incurred prior to such date that was used to satisfy any part of a Deductible Amount will be eligible for reimbursement, however.

When the policyholder has chosen to include a maximum dollar amount of deductible required to be satisfied by a family, the following language will be added to the paragraph DEDUCTIBLE AMOUNT or added by rider. This dollar amount may be per Benefit Period, Quarter, or Lifetime and ranges from $0 - $300 in $5 increments.

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that [Benefit Period] [Quarter] [their Lifetime].

Maximum Family Deductible $[150]

When the policyholder has chosen to include a maximum dollar amount of Deductible required to be satisfied by a family with different amounts when choosing a Participating versus Non-Participating Provider, the following language will be added to the paragraph DEDUCTIBLE AMOUNT or added by rider. The dollar amounts may be by Benefit Period, Quarter, or per Lifetime and range from $0 - $300 in $5 increments:

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that [Benefit Period] [Quarter] [their Lifetime].

	Participating Provider	Non-Participating Provider

Maximum Family Deductible	$[100]	$[150]

The paragraph regarding Deductible Takeover will be removed if the plan design selected does not include benefits for Takeover.

COINSURANCE PERCENTAGE

The Coinsurance Percentage can range between 0% to 100% in increments of 5%.

Type 1 Procedures	25% - 100%
Type 2, 3, or 4 Procedures	0% - 100%

If the Plan Allowance selected by the policyholder is on a scheduled basis or is based solely on the Actual Charge of the provider the following is included next to the Coinsurance Percentage for clarification purposes:

Coinsurance Percentage:	
Type 1 Procedures	25% - 100% [of Schedule, of Actual Charges]
Type 2 Procedures	0% - 100% [of Schedule, of Actual Charges]
Type 3 Procedures	0% - 100% [of Schedule, of Actual Charges]
Type 4 Procedures	0% - 100% [of Schedule, of Actual Charges]

If the Coinsurance Percentage is different when utilizing a Participating Provider versus a Non-Participating Provider the Coinsurance Percentage will be as listed in the example below:

Coinsurance Percentage:	Participating Provider	Non-Participating Provider
[Type 1 Procedures]	[25% - 100%]	[25% - 100%]
[Type 2 Procedures]	[0% - 100%]	[0% - 100%]
[Type 3 Procedures]	[0% - 100%]	[0% - 100%]
[Type 4 Procedures]	[0% - 100]	[0% - 100%]

The difference between participating and non-participating providers will not exceed state allowances.

If an Incentive Coinsurance Percentage is selected it will be as listed in the **example** below. The Incentive Coinsurance Percentage amounts will also vary from 0% - 100% in increments of 5%. It may also be separated into Participating Provider versus Non-Participating Provider amounts, similar to the above, if the Coinsurance Percentage is different when utilizing a Participating Provider versus Non-Participating Provider and determined on an Incentive basis.

Coinsurance Percentage:	
Type 1 Procedures:	
Step 1.	70%
Step 2.	80%
Step 3.	90%
Step 4.	100%
Type 2 Procedures:	
Step 1.	50%
Step 2.	60%
Step 3.	80%
Step 4.	90%
Type 3 and Type 4 Procedures:	
Step 1.	25%
Step 2.	35%
Step 3.	50%
Step 4.	60%

If an Incentive Coinsurance Percentage is selected, a descriptive paragraph outlining when the Insured moves between the Steps will be included. The Coinsurance Steps range from two steps up to four steps. The Coinsurance Percentage as listed will be adjusted to accurately reflect the number of steps included in the plan design. The dates used below are illustrative, the appropriate dates based on the policyholder's actual effective date will be used. Below are the Incentive Method descriptive paragraph options that can be selected:

1. Effective Date Incentive:

[For those persons insured on [January 1, 2009] Step [3] applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person fails to visit a dentist or fails to have a dental procedure performed, Step 1 will automatically reapply during the following Benefit Period, and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

2. Date of Hire Incentive:

A. The Coinsurance Percentage Steps for those persons insured after [January 1, 2009], will be determined as follows:

    1. Step 1 applies during the first Benefit Period the person becomes insured.

    2. If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 and 3 will apply during the second and third Benefit Period, respectively, and Step 4 will apply during each Benefit Period after.

    3. If, during any Benefit Period, the person fails to visit a dentist to have a dental procedure performed, Step 1 will automatically reapply during the following Benefit Period, and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

        Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

B. The Coinsurance Percentage Steps for those persons insured on [January 1, 2009], will be determined as follows:

    Step 1 Those employed in [2009].

Step 2 Those employed in [2008].

Step 3 Those employed in [2007].

Step 4 Those employed prior to [2007].

1. Any such person between [January 1, 2009], and [December 31, 2009] will advance to the next higher Coinsurance Percentage Step on January 1, [2010].

2. Any person falling in #1 above who does not visit a dentist during [2010] and have a dental procedure performed, will revert to Step 1 on January 1, [2011]

3. Any person who has advanced to the next higher Coinsurance Percentage Step will advance to the next higher step if during each Benefit Period, he or she visits a dentist and has a dental procedure performed. If this is not done, however, the person will revert to Step 1 on the next following January 1 and must advance to Steps 2, 3 and 4 as if he or she were newly insured.

3. Progressive Incentive:

[For those persons insured on [January 1, 2009] Step [2] applies during the first Benefit Period the person becomes insured.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

4. New Date of Hire Incentive:

A. The Coinsurance Percentage Steps for those persons insured after [January 1, 2009], will be determined as follows:

1. Step 1 applies during the first Benefit Period the person becomes insured.

2. If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 and 3 will apply during the second and third Benefit Period, respectively, and Step 4 will apply during each Benefit Period after.

3. If, during any Benefit Period, the person fails to visit a dentist to have a dental procedure performed, Step 1 will automatically reapply during the following Benefit Period, and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

B. The Coinsurance Percentage Steps for those persons insured on [January 1, 2009], will be determined as follows:

Step 1 Those employed in [2009].

Step 2 Those employed in [2008].

Step 3 Those employed in [2007].

Step 4 Those employed prior to [2007].

1. Any such person between [January 1, 2009], and [December 31, 2009] who does not visit a dentist during [2009] will remain at the same Step that applied during [2009].

2. Any person who has advanced to the next higher Coinsurance Percentage Step will advance to the next higher step if during each Benefit Period, he or she visits a dentist and has a dental procedure performed. If this is not done, however, the person will revert to Step 1 on the next following January 1 and must advance to Steps 2, 3 and 4 as if he or she were newly insured.

5. Family Progressive Incentive:

[For those persons insured on [January 1, 2009] Step [3] applies during the first Benefit Period.

For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period.

or

Step 1 applies during the first Benefit Period.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

Step 2 will apply during the second Benefit Period.

Step 3 will apply during the third Benefit Period.

Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

6. 10% Advance Incentive:

[For those persons insured on <MDY(cDivEffDate)> Step <nDenStart> applies during the first Benefit Period the person becomes insured.

For those persons insured after <MDY(cDivEffDate)> Step 1 applies during the first Benefit Period the person becomes insured.

or

Step 1 applies during the first Benefit Period the person becomes insured.]

If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.

If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.

If, during any Benefit Period, the person fails to visit a dentist or fails to have a dental procedure performed, the coinsurance percentage drops back one Step. The coinsurance percentage will never be less than the coinsurance percentage in Step 1.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

7. Date of Hire progressive Incentive:

A. The Coinsurance Percentage Steps for those persons insured after [January 1, 2009], will be determined as follows:

1. Step 1 applies during the first Benefit Period the person becomes insured.

2. If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 and 3 will apply during the second and third Benefit Period, respectively, and Step 4 will apply during each Benefit Period after.

3. If, during any Benefit Period, the person fails to visit a dentist to have a dental procedure performed, the person will remain at the same Step that applied during the previous Benefit Period.

   Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

B. The Coinsurance Percentage Steps for those persons insured on [January 1, 2009], will be determined as follows:

Step 1 Those employed in [2009].

Step 2 Those employed in [2008].

Step 3 Those employed in [2007].

Step 4 Those employed prior to [2007].

1. Any such person between [January 1, 2009], and [December 31, 2009] will advance to the next higher Coinsurance Percentage Step on January 1, [2010].

2. Any person falling in #1 above who does not visit a dentist during [2010] and have a dental procedure performed, will remain at the same Step that applied during the previous Benefit Period.

3. Any person who has advanced to the next higher Coinsurance Percentage Step will advance to the next higher step if during each Benefit Period, he or she visits a dentist

and has a dental procedure performed. If this is not done, however, the person will remain at the same Step that applied during the previous Benefit Period.

8. Date of Hire Advance Incentive:

A. The Coinsurance Percentage Steps for those persons insured after [January 1, 2009], will be determined as follows:

1. Step 1 applies during the first Benefit Period the person becomes insured.

2. If the person visits a dentist during each Benefit Period and has a dental procedure performed, Step 2 and 3 will apply during the second and third Benefit Period, respectively, and Step 4 will apply during each Benefit Period after.

3. If, during any Benefit Period, the person fails to visit a dentist to have a dental procedure performed, the insured person's coinsurance level will drop back one coinsurance level step.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than twelve months, the insured person's coinsurance level will revert back one coinsurance level step for every 12 months of the break.

B. The Coinsurance Percentage Steps for those persons insured on [January 1, 2009], will be determined as follows:

Step 1 Those employed in [2009]

Step 2 Those employed in [2008]

Step 3 Those employed in [2007]

Step 4 Those employed prior to [2007]

1. Any such person insured between [January 1, 2009], and [December 31, 2009] will advance one step to the next higher Coinsurance Percentage Step on [January 1, 2010], if they have visited a dentist and had a dental procedure performed. Initial insured employees and dependents will remain at the same coinsurance level step during [2010] if they fail to visit the dentist and have one dental procedure performed.

2. For every January 1, thereafter, should any person fail to visit the dentist in any calendar year, or should he or she fail to have at least one dental procedure performed within the given year, the person will drop back one coinsurance level step, but never below the original Step 1 coinsurance level.

Exception: If, during any Benefit Period, the person has a break in continuous coverage of more than twelve months, the insured person's coinsurance level will revert back one coinsurance level step for every 12 months of the break.

MAXIMUM AMOUNT

The Maximum Amount can range between $250 to $10,000 or more in increments of $50 dependent upon plan selection.

If the Maximum Amount is different when utilizing a Participating Provider versus a Non-Participating Provider the Maximum Amount will be listed as following:

When a Non-Participating Provider is used:

Maximum Amount - Each Benefit Period	$[1,000]
When a Participating Provider is used: Maximum Amount - Each Benefit Period	$[1,250]

If certain procedures will not count toward the Maximum Amount, a sentence such as the following will be added to the paragraph MAXIMUM AMOUNT:

In no event will expenses incurred for Type [1] Procedures count toward the Maximum Benefit.

If an Internal Maximum is selected the following text will be used. This could apply to any of the Benefit Types or may apply to procedures for Temporomandibular Joint Dysfunction. The dollar amount listed will vary based on plan selection. This Internal Maximum may apply each "Benefit Period" or "per Lifetime".

Type [3] Eligible Dental Expense Benefits may not exceed [$500] [per Lifetime, in any Benefit Period].

ELIMINATION (WAITING) PERIODS

Elimination Periods may be included based on plan selection. If included, the Elimination Period will be one of the following 3, 6, 9, 12, 18, or 24 months. The Elimination period may also apply to different Benefit Types and/or multiple Benefit Types. For example the Elimination Period could be 6 months on Type 2 Procedures and 12 months on Type 3 Procedures. If no Elimination Period applies, the entire paragraph will be removed.

ORTHODONTIC EXPENSE BENEFITS

The Orthodontic Maximum Amount can range between $250 to $10,000 or more in increments of $50 dependent upon plan selection.

The Maximum Amount for Orthodontic Expense Benefits can be applied "During Lifetime" or "each Benefit Period" or both.

If the Deductible Amount, Coinsurance, or Maximum Amount for Orthodontic expense benefits is different when utilizing a Participating Provider versus a Non-Participating Provider these amounts will be listed similar to the following:

	Participating Provider	Non-Participating Provider
Deductible Amount - Once per lifetime	$100	$150
Coinsurance Percentage	60%	50%
Maximum Benefit During Lifetime	$1,500	$1,000

An Elimination Period for Orthodontic Expense Benefits may be included based on plan selection. If included the Elimination Period will be 12, 18, or 24 months.

If the policyholder has selected a plan with Takeover for Orthodontic Expense Benefits, the following will be listed:

The Maximum Benefit shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier

on [January 1, 2009], and

b. on [January 1, 2009] is both:

i. insured under the policy, and

ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

a. the normal benefit payable under the policy for the current Treatment Program, minus

b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.

Similar to the Dental Maximum Amount, if an internal maximum on Orthodontic Expense Benefits exists the following will be included:

Orthodontic Expense Benefits may not exceed $[1,000] [in any Benefit Period, per Lifetime].

If the Policyholder has selected a plan in which the deductible for Dental and Orthodontic Expense Benefits are combined together so that the member only has to satisfy one deductible, the following will be included:

[1] The deductible is combined for both the Dental Expense and the Orthodontic Expense Benefits.

EYE CARE EXPENSE BENEFITS

When the Policyholder has not chosen a PPO (or Participating Provider) option, all references to participating and non-participating providers are deleted.

The Deductible Amount for Eye Care Expense Benefits can range from $0 to $25 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime". The Deductible Amount may also be applied to any and/or multiple Eye Care Benefits. For Example a $25 Deductible on Lenses and Frames - Each Benefit Period. The deductible may also vary whether a Participating Provider or Non-Participating Providers is used.

The Maximum Amount for Eye Care Expense Benefits can range from $50 to $300 in $50 increments or may be removed entirely if not included in the selected plan design.

Some services such as eye care exams, frames, or lenses may not apply to the Eye Care Maximum. If the policyholder has selected this plan than the following will be included:

[Eye Care Exams] are not subject to the Eye Care Maximum Amount.

LASER VISION CORRECTION EXPENSE BENEFITS

The Deductible Amount for Laser Vision Correction Expense Benefits can range from $0 to $250 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime".

The Coinsurance Percentage for Laser Vision Correction Expense Benefits can range from 50% - 100% in 5% increments. Normally it remains at 100%. Similarly to the Dental Expense Benefits Coinsurance

Percentage the Percentage can be on an incentive basis starting at 50% and increasing to as much as 100% over 2 - 4 years.

If the Incentive Coinsurance option is selected by the policyholder the following will also be included:

> [For those persons insured on [January 1, 2009] Step [2] applies during the first Benefit Period the person becomes insured.
>
> For those persons insured after [January 1, 2009] Step 1 applies during the first Benefit Period the person becomes insured.
>
> or
>
> Step 1 applies during the first Benefit Period the person becomes insured.]
>
> *If a plan includes Takeover benefits the first two paragraphs above will be included to allow those that qualify for Takeover to start at a higher Coinsurance Percentage. If a plan does not include Takeover benefits only the last sentence above will be included.*
>
> Step 2 will apply during the second Benefit Period, Step 3 during the third Benefit Period, and Step 4 will apply during each Benefit Period after.
>
> If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Steps 2, 3 and 4 as if he or she were newly insured.

HEARING CARE EXPENSE BENEFITS

Deductible Amounts for Hearing Expense Benefits can range between $0 to $250 in increments of $5 dependent upon Policyholder selection. Deductible Amounts can be applied by Benefit Period, Quarter, Annually, per Visit, and per Lifetime. Deductible Amounts can also be combined to apply to more than one Hearing Benefit Type. For Example, a $50 per Benefit Period deductible can apply to Hearing Exams, Hearing Aids, and Hearing Aid Maintenance. The Deductible Amount listed on the Schedule of Benefits page is indicative of one of the most popular plan designs.

When the policyholder has chosen to include a deductible carry-over provision on hearing expense benefits, the following language will be added to the paragraph DEDUCTIBLE AMOUNT, on the Schedule of Benefits:

> If an Insured incurs Covered Expenses:
>
> i. during the last <u>three</u> months of any Benefit Period; and
>
> ii. these expenses are applied towards the Deductible Amount for that Benefit Period,
>
> Such Covered Expenses will also apply to the Deductible Amount for the following Benefit Period.

The Coinsurance Percentage for Hearing Expense Benefits can range from 50% to 100% based on Policyholder selection and our own coverage philosophy.

The Hearing Aid Maximum Amount can apply to "both ears" or "per ear". It may increase from as little as 2 12-month periods up to 4 12-month periods. The dollar amounts can range from $400 - $1,500 dollars in $50 increments.

COMBINED EXPENSE BENEFITS

The Deductible Amount for Combined Expense Benefits, if selected by the policyholder, can range from $10 to $250 based on plan selection. This amount can be applied "Each Benefit Period" or "Once per Lifetime".

In addition, an aggregate deductible amount may be included per lifetime. This would be a deductible amount limit that an Insured would satisfy once per lifetime then no other deductible would be required. If selected by the policyholder, the following would be included:

*Combined Dental and Eye Care Deductible Amount $200
Once per Lifetime
The combined [Annual, Lifetime] deductible is subject to the Aggregate Lifetime deductible amount listed here.

The Combined Maximum Amount, if selected by the policyholder, can range from $250 to $10,000 or more in increments of $50 based on plan selection.

The Combined Exam Frequencies, if selected by the policyholder, can range from 1 to 4 Exams - Each Benefit Period or a rolling period of months based on plan selection. If applicable, the rolling number of months may be 6 months or 12 months.

The procedures listed may be changed to match the procedures listed on the 9232 Table of Dental Procedures that qualify as Dental Exams.

EYE CARE EXAM BENEFIT – 9041

The Eye Care Exam Benefit is optional and may be removed entirely if it is not included in the plan design.

This benefit can be sold with or without a Participating Provider Option. Therefore, if issued without a participating provider option, these specific provisions will be deleted.

If sold with a PPO option, then there are two available plan designs, one utilizing the Vision Service Plan ("VSP") panel of eye care providers, the other is EyeMed Vision Care, LLC, ("EyeMed"). Depending upon the panel selected, the appropriate name will print.

INCREASED DENTAL MAXIMUM BENEFIT – 9042

The various ranges are shown within the bracketed areas. They are as follows:

Carry Over Amount per Insured Person – Each Benefit Period	[$ 125, 250, 400]
Benefit Threshold per Insured Person – Each Benefit Period	[$ 250, 500, 750]
PPO Bonus	[$ 50, 100, 150, 200]
Maximum Carry Over Amount	[$ 500, 1,000, 1,200]

If the PPO Bonus or Increased Maximum Takeover options are not selected, references to those options will be removed.

The sentence "[This proof must be furnished to us within 12 months of the Policy Effective Date and not be for a Date of Services more than 12 months prior to the date the proof is furnished.]" may be removed if an option to transfer Carry Over Amounts from a prior carrier is selected.

The dollar amount of the Increased Maximum Takeover can range from $250 to $600 in $50 increments.

LASER VISION CORRECTION BENEFIT RIDER – 9043

Benefits are lifetime maximums and payable per eye. No benefit will be payable for multiple laser vision correction treatments on the same eye.

The lifetime maximum per eye may vary by benefit period as shown. The policyholder will select the lifetime maximum amounts. The available dollar maximums are shown in the bracketed portions of the form. The policyholder will also select the number of Benefit Periods the dollar amount may be increased by.

Any limitation or any of the sub-items could be deleted based on our coverage philosophy.

a. There may or may not be an elimination period. If there is an elimination period, the period may be 12 months.
b. No benefit will be payable for an Insured Person under a defined age which may vary from 18 – 21 as shown.
c. There may or may not be a Late Entrant provision. If there is a Late Entrant provision, the waiting period may be 6 or 12 months.

The numbers and definitions of the procedure codes listed are variable to allow for changes by HCPCS and our own coverage philosophy.

The Benefit Period definition contains the variables [January 1] and [December 31]. These variables can be any month and day, i.e., January 1 – December 31st, dependent upon the Policyholder's plan year.

Officer Name and Signature. We wish to reserve the right to change the officer name and signature should they change in the future.

ACCIDENTAL LOSS OF SIGHT BENEFIT RIDER – 9044

The dollar amounts listed may vary based on policyholder request and our coverage philosophy.

Any limitation or any of the sub-items could be deleted based on our coverage philosophy.

TABLE OF MONTHLY PREMIUM RATES – 9050

The rate table will reflect the rate structure selected by the Policyholder, which could include: Insured/Dependent Unit, Insured/Spouse/Children Only/Spouse and Children, or One Dependent/Two or More Dependents.

The 3 month variable could be modified to extend to a longer period, e.g., 6 or 12 based on plan selection.

The 31 day advance written notice could be modified to 45, 60 etc. days, but never less than the number required by the state law.

If a policyholder has subsidiaries, multiple locations, etc. which are covered under the group policy, these subsidiaries, locations would be listed here.

Based on the case criteria and upon request of the Policyholder, the policy can be issued with an expanded rate guarantee period of 24 months. This extended period is conditional upon the items listed within the provision. A 12-month guarantee period is the standard provision.

DEFINITIONS – 9060

i. If the policyholder elects to add "Domestic Partner" coverage, then the applicable definition and reference to "domestic partner" will be added. This variable will not be used if such partnership is not recognized by state law where the policy is delivered.

ii. If the Dependent option is not selected, all references to Dependent will be omitted. This includes definitions of Total Disability and Dependent Unit.

The ages contained in the definition for Dependent could be changed downward and upward depending on the policyholder's wishes (18-30) or will reflect that as required by state law.

We understand that the initial reforms in the federal Patient Protection and Affordable Care Act are not intended to apply to standalone dental or vision policies; however, we have developed language in our policy to allow for applicants and policyholders to elect to align their dental benefit age with their new medical policy definition of dependent, if they choose. Our currently approved dependent language will remain in the policy unless the policyholder chooses this alternate definition. To identify these options as variable, there are text boxes around both definitions of dependents. Only one option can be elected.

iii. Late Entrant will be removed if the Insured is not a Late Entrant.

iv. The dates within the Benefit Period definition will be based on the Policyholder's plan year.

In addition if a policyholder has selected to allow dependents to continue on the plan until the end of the calendar year, the following will be included for item b. and c. of the dependent definition:

i. each unmarried child through the end of the year in which they turn age [19], for whom the Member, the Insured's spouse, [or the Insured's Domestic Partner,] is legally responsible, including:

ii. each unmarried child from the end of the calendar year in which they turn age [19] up to the end of the calendar year in which they turn age [24] who is:

The definition for TOTAL DISABILITY may be removed entirely if the policy is issued to a non-employer group.

CONDITIONS FOR INSURANCE COVERAGE – 9070

Any reference to employer or employee will be removed if this product is issued to an association or any other non Employer-Employee group.

ELIGIBILITY

The definition of Active Service could be changed to whatever a policyholder requires. For example, union employees and school districts would use a different definition.

All definitions of eligible employees and dependents could be modified as required by the policyholder. Variations include: full, part-time or seasonal, active or retired, number of hours worked per week, excluding certain classes of employees, and plans where the participation in the policyholder's medical plan is required for participation in our dental and/or eye care plan.

The paragraphs under Eligibility relating to husbands and wives working for the same employer are optional as requested by the policyholder.

When the policyholder has an existing dental HMO plan offered by another insurance company the following will be included.

Employees who are enrolled in the Prepaid Plan are not members of the Eligible Class for Personal Insurance and are excluded from the coverage under this policy.

ANNUAL ENROLLMENT SWITCH PERIOD Any employee above who has been covered by the Prepaid Plan for six (6) months or more may become a Member under this policy at any Annual Enrollment Switch period. A thirty-one (31) day Annual Enrollment Switch period will be held each [December] to be effective [January 1]. The Late Entrant penalty and the Waiting Period will be waived for such employee, enrolled in the Prepaid Plan, who becomes a Member during an Annual Enrollment Switch period if certain conditions are met.

When an individual insured has the option to elect between various plan designs, the following paragraphs may be added since the employee may have the option to move between Classes during an open enrollment period as defined by the policyholder, the policyholder may request that one of the following definitions be added to the eligibility provision to avoid adverse selection:

Annual Enrollment Switch Period

An Annual Enrollment Switch period will be held each [December] to be effective [January 1] to allow members to move from Class [1 – Exam Only] to Class [2 - Exam and Materials]. However, if a member terminates from the Class [2 plan option -Exam and Materials], they are not eligible to re-enroll within Class [2 -Exam and Materials] for [two (2)] year(s).

ANNUAL ENROLLMENT SWITCH PERIOD. An Annual Enrollment Switch Period for the eye care plans will be held each [December] to be effective [January 1] to allow members to move from one eligible eye care Class to another eligible eye care Class. However, if a member terminates from the eye care Class they have elected, they are not eligible to re-enroll within an eligible eye care Class until the next Annual Enrollment Switch Period.

In the section entitled ELIGIBLE CLASS FOR DEPENDENT INSURANCE, the reference to the 2nd birthday can also be changed to the 3rd birthday based on the policyholder's selection or our own coverage philosophy.

CONTRIBUTION REQUIREMENTS

Contribution requirements can vary by class of employee and can vary for the Member versus the Dependents. The contribution requirements will reflect what is required by the policyholder of their members.

If the policyholder ties the contribution to their medical plan the following will be included:

An Insured may or may not be required to contribute to the payment of his or her insurance premiums.

If the policyholder has chosen to not require the member to pay for premium if they are not otherwise on another dental and/or eye care plan the following will be included:

An Insured is not required to contribute to the payment of his or her insurance premiums. An insured may or may not be required to contribute to the payment of insurance premiums if he or she is both covered under this policy and also covered under another plan.

SECTION 125

If the policyholder has a Section 125 plan, then, based on the Section 125 and the plan year, one of the following paragraphs would be included:

When the policy year and the Section 125 plan year coincide:

> **SECTION 125. [(Dependents Only)]** This policy is provided as part of the Policyholder's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.
>
> If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on [date]. [A Member who elects to participate during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. [X] on [9219]. (There is NO "open enrollment" under this policy.)]
>
> Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

When the policy year and the Section 125 plan year do not coincide:

> **SECTION 125. [(Dependents Only)]** This policy is provided as part of the Policyholder's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.
>
> If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Annual Election Period. The first Annual Election Period will be in [December 2009] and those who elect to participate in this program at that time will have their insurance become effective on [January 1, 2010]. Each Annual election Period thereafter will be in [June] for a [July 1] effective date. [A Member who elects to participate during an Election Period who did not elect to participate when initially eligible will be a Late Entrant and subject to Limitation No. [X] on [9219]. (There is NO "open enrollment" under this policy.)]
>
> A Member may change their election option only during an Annual Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

If the Section 125 rules only apply to Dependents then the optional "Dependents Only" listed above will be included. When the policyholder has elected to have an annual open enrollment each year or does not have a late entrant provision, the bracketed sentence about Late Entrants will be removed.

ELIGIBILITY PERIOD

Eligibility Periods can vary from no waiting period to whatever the policyholder wishes. The eligibility period will never be any longer than prescribed by state law. Eligibility Periods can vary by class of employee and vary between existing employees and newly hired employees.

The reinstatement paragraph under Eligibility Period could be modified to include a time period as required by the Policyholder or deleted, allowing for no reinstatement.

If the policyholder elects to include an annual open enrollment the following will be included. The reference to Dependents only will only be included if the annual open enrollment only applies to dependents.

> **OPEN ENROLLMENT. [(Dependents Only)]** If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on [date].

EFFECTIVE DATE

The date the person becomes effective, whether premium contributions are or are not required, could be changed either on the page or by rider. Examples of changes are:

Effective "on the date".

Effective "on the first of the month"

Effective "on the fifteenth (or whatever) of the month".

Showing different effective dates for different classes of employees.

The section entitled EXCEPTIONS may be removed entirely if the policy is issued to a non-employer group.

TERMINATION DATES

The termination date could be changed similarly to the effective date variables shown above.

CONTINUATION OF COVERAGE. Any state required continuation provisions will be included within this section per individual state requirements.

DENTAL EXPENSE BENEFITS – 9219 and all variations

PARTICIPATING PROVIDER (PPO) OPTION. When the Policyholder has not chosen a PPO (or Participating Provider) option, all references to participating and non-participating providers are deleted.

PROCEDURE CLASSIFICATION. Typically our dental procedures are grouped into Type 1, Type 2, and Type 3. However, we may choose to designate these procedural groups with other terms such as "Level 2" or "Type A". When Type 1 and Type 2 benefits only are written, any references to Type 3 procedures or limitations on Type 3 procedures are deleted.

COVERED EXPENSES. The basis on which we will pay dental benefits is based on the plan selected by the Policyholder. Several options are available. Benefits will be the lesser of: (1) the actual charge of the provider; and any one or more of the possibilities shown in the paragraph COVERED EXPENSES. This includes the usual and customary (“U&C”) as determined by us; Maximum Covered Expense (which is a scheduled basis), Maximum Allowable Benefit (“MAB”), Maximum Procedure Allowance (“MPA”), and Maximum Allowable Charge (“MAC”).

EXPENSES INCURRED. In the paragraph EXPENSES INCURRED, if appliances are not covered, the first sentence is deleted. If dental prosthesis or prosthetic crowns are not covered, the second sentence is deleted entirely or modified. If root canal therapy is not covered, the third sentence is deleted.

LIMITATIONS

When only certain Type benefits (i.e., Type 1 and Type 2 only) are written, any references to other Type procedures or limitations are deleted.

Any limitation or any of the sub-items could be deleted based on our coverage philosophy.

The time limitation of 6-months in the Limitation concerning an elimination period for a specific procedure Type, normally Type 3, could be changed to reflect 3, 9, 12, 18 or 24 months based on various anti-selection factors. Normally it remains at 6 months. Multiple limitations will be included if the time

limitation applies to multiple Benefit types such as Type 2 and Type 1 as well as Type 3 or this limitation will be removed entirely if no time limitation exists.

The Late Entrant limitation which is filed variable at 12-months could be shortened or lengthened based upon plan selected.

We have several late entrant options that can be selected by the Policyholder:

a. There are late entrant methods that involve the # of months that an insured has limited coverage. The # of months can apply to some or all of our procedures for the length of time selected by the Policyholder. Plans may include some, none, or accidental only coverage for a limited time.

b. There are dollar amount maximums that can be selected. For example, $100 maximum for the 1st 12 months; $300 maximum for the 2nd 12 months. The maximums can be applied to all procedures or selected procedure types.

c. There are percentages that can be selected. For example, 50% of the allowed benefit would be paid in the first 12 months. The percentage can be applied to all procedures or selected procedure types.

The limit on replacement of teeth extracted prior to coverage under this plan may vary. We have several plan options that can be selected by the Policyholder:

a. NO PRIOR EXTRACTION COVERAGE. Covered Dental Expenses for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

b. LIMITED PRIOR EXTRACTION COVERAGE. Provides for a procedure to replace teeth extracted while insured was under a prior plan, applies to initial insureds only. A 12-month maximum time period between extraction (while insured under prior plan) and replacement (while insured under our plan).

c. FULL PRIOR EXTRACTION COVERAGE provides benefits for a procedure performed to replace a tooth or teeth extracted before the person's effective date under our plan.

d. FOREVER PRIOR EXTRACTION COVERAGE provides for a procedure to replace a tooth or teeth extracted while under a prior plan, applies to initial insureds only. No coverage for missing teeth for 24 months, then full prior extraction coverage.

   50% of amount otherwise payable to replace the missing tooth will be paid the first 24 months, then full prior extraction coverage. (The allowance will be cut in half at the procedure level and then the regular coinsurance will be applied.)

   For 'Initial Insureds', the insureds will be eligible for full prior extraction coverage. Insureds who become effective after the policy effective date will not be eligible for prior extraction coverage.

e. DATE OF HIRE: No coverage for missing teeth for 36, 48, or 60 months from employee date of hire, then full prior extraction coverage.

f. EFFECTIVE DATE: No coverage for missing teeth for 36 months from Policyholder effective date, then full prior extraction coverage.

Initial insureds will be eligible for full prior extraction coverage. Insureds effective after policy or division effective date; no coverage for missing teeth for 36 months from effective date, then full prior extraction coverage.

Initial insureds will be eligible for full prior extraction coverage. Insureds effective after policy or division effective date; no coverage for missing teeth for 36 month from date of hire, then full prior extraction coverage.

The replacement limitation could include veneers and/or implants, if the plan includes that coverage. Any reference to the procedures will be removed if they aren't covered under the plan and the number of years limit could be lengthened or shortened based on the plan design chosen by the policyholder.

The 90-day extension of coverage for certain procedures could be modified if required by the Policyholder. The clause regarding dental appliances could be deleted if prosthetic dental appliances are not covered.

Any limitations on work-incurred injury and sickness would be deleted should we be requested by the policyholder to provide occupational (24 hour) coverage.

TABLE OF DENTAL PROCEDURES – 9232

The entire lists of procedures, including procedure definition, American Dental Association (ADA) code numbers, etc., are optional and can be removed, regrouped or modified by rider. Additional ADA codes can be added as necessary. Procedures may be moved between types, grouped or designated in another way, such as "Level 2" or "Type A". If this were to occur, we would print new pages with the procedures listed under the appropriate type. The numbers and definitions are variable to allow for changes by the ADA and our own coverage philosophy.

The dates within the Benefit Period definition will be based on a Calendar Year, the Policyholder's plan year, an Insured Benefit Year, or a Member Benefit Year. The Benefit Period definition contains the variables [January 1] and [December 31]. These variables can be any month and day, i.e., January 1 – December 31st, dependent upon the Calendar Year or the Policyholder's plan year.

If an Insured Benefit Year is chosen by the Policyholder the following is listed:

Benefit Period means a period of (12) calendar months. A Benefit Period will start on the Insured's Effective Date through the anniversary date of that date each year thereafter.

If a Member Benefit Year is chosen by the Policyholder the following is listed:

Benefit Period means a period of twelve (12) calendar months. A Benefit Period will start on the date the insurance becomes effective for each Individual. Each Benefit Period thereafter will start on the anniversary date of that date.

Limitations which are not included on the Dental Expense Benefits page that are specific to certain procedures may be included within the procedural category within this Table.

ORTHODONTIC EXPENSE BENEFITS – 9260/9260 - Takeover

The Usual and Customary paragraph can be removed entirely if a plan design to pay the actual charge of the provider is selected.

The Maximum Amount definition can be changed to allow for a definition of a Maximum that is each Benefit Period or that is both per Lifetime and per Benefit Period.

The reference to "eight calendar quarters" or "calendar quarters" in TREATMENT PROGRAM and EXPENSES INCURRED may be modified for more or fewer quarters, or to change "quarters" to "months", "semi-annual", or "annual" payments, etc.

If a plan is selected that provides for an amount of Orthodontic Expenses to be covered "up front" then the following sentence will be added to the last paragraph under Expense Incurred. This could be a specified dollar amount or a percentage of the Orthodontic Maximum Amount.

> However, the first payment will be [25 percent] of the total allowed Covered Expense.

Any limitation or any of the sub-items could be deleted based on our coverage philosophy.

The age limitation is deleted when we offer "adult" ortho. Adult ortho would provide benefits for the Insured, Insured's spouse, and adult dependent children.

The age 17 could be changed if required by policyholder or based on our coverage philosophy. If the age is changed to 19 then the word "begun" will be removed to indicate that the ortho program will cease upon the Insured reaching their 19th birthday.

The elimination period of 12 months could be modified based on policyholder negotiations. Normally it remains at 12 months.

The Late Entrant Provision limitation can be modified similar to the options for Late Entrants listed for Dental Expense Benefits or removed entirely as required by the policyholder or based on our coverage philosophy.

Any Limitations on work-incurred injury or sickness would be deleted should we be requested by the policyholder to provide occupational (24 hour) coverage.

EYE CARE EXPENSE BENEFITS/EYE CARE INSURANCE – 9270/9280

Frequency limitations may be on a rolling frequency basis (every 12 or 24 months) or on a benefit period basis. The type of frequency provision is dependent upon the plan design selected by the Policyholder. Therefore, the Benefit Period definition will be included if the plan design includes a benefit period frequency limitation. If the frequency limitation is a rolling frequency, then this paragraph will not print.

The Benefit Period definition contains the variables [January 1] and [December 31]. These variables can be any month and day, i.e., January 1 – December 31st, dependent upon the Policyholder's plan year.

The frequency limitation in Limitation Nos. 1, 2, 3 or 4 will either be a 12 or 24 month period (rolling frequency) or a benefit period frequency depending upon the plan design selected by the Policyholder as referenced above.

Any limitation could be deleted entirely or any of the sub-items based on the plan design selected by the Policyholder.

The entire list of services is optional and can be removed or modified based on the plan design selected by the Policyholder. The dollar amounts listed are variable and provided for illustrative purposes. The actual dollar amount allowance will be based on the most recent approved rate for each procedure for states that require rate filing and approval. The scheduled amounts are reviewed at least annually in light of market conditions.

When a member utilizes a participating provider, the participating provider offers a reduction in the member's out of pocket expenses for specific services, which may or may not be a covered expense as listed in the schedule of eye care services. This reduction is a non-insurance benefit and is provided at

no additional cost to the member or the group. A reduction on any service will be outlined on the schedule of eye care services upon a policyholder's request. A member may contact us or their plan administrator for instructions on how to obtain information related to this reduction.

The available plan design options provide for either a scheduled amount (Maximum Covered Expense) per service or may be an aggregate Eye Care Maximum, e.g., $250 for any services selected by the Insured. This will be reflected in the Schedule of Eye Care Services. If the aggregate amount is selected the following will be added to the Schedule of Eye Care Services.

[Maximum Amount - Each Benefit Period [$50 - $300]]

HEARING CARE EXPENSE BENEFITS PAGES - 9290

Any limitation could be deleted entirely or any of the sub-items based on our coverage philosophy or policyholder negotiation.

The entire list of procedures are optional and can be removed or modified. The dollar amounts listed are variable and provided for illustrative purposes. The Policyholder can select an option that includes all of the procedures, exams only, or materials only (hearing aids, maintenance, and/or miscellaneous).

The Benefit Period definition contains the variables [January 1] and [December 31]. These variables can be any month and day, i.e., January 1 – December 31st, dependent upon the policyholder's plan year.

The Late Entrant provision which is filed variable at 12-months could be shortened or lengthened based upon Policyholder negotiations.

We have several late entrant options that can be selected by the plan holder:

a. There are late entrant methods that involve the # of months that an insured has limited coverage. The # of months can apply to some or all of our procedures for the length of time selected by the Policyholder. Plans may include some, none, or accidental only coverage for a limited time.

b. There are dollar amount maximums that can be selected. For example, $100 maximum for the 1st 12 months; $300 maximum for the 2nd 12 months. The maximums can be applied to all procedures or selected procedure types.

c. There are percentages that can be selected. For example, 50% of the allowed benefit would be paid in the first 12 months. The percentage can be applied to all procedures or selected procedure types.

COORDINATION OF BENEFITS - 9300

The reference to type of coverage provided under the policy, i.e., dental and/or eye care coverage, will be reflected accordingly based on the actual policy issued.

GENERAL PROVISIONS - 9323

PARTICIPATION. Participation requirements will be reflected based on census of group. For non-contributory plans, 100% participation required for all eligible employees and dependents.

Under TERMINATION OF THE POLICY, the provision allowing us to terminate the policy for reasons other than participation may be left off the form or deleted by rider based on our coverage philosophy. (Note: This provision is not available in all states.)

AMENDMENT RIDER - 9010

This rider will be primarily used after the group policy has been issued to reflect any policy changes requested by the policyholder and/or to reflect any corrections made at the time of issue. All material shown on the rider and below is illustrative. The signature and title lines at the bottom of the policy riders are deleted when the policyholder is not required to sign for the policy change (ex. when we correct an error we made issuing the policy and/or we receive confirmation of the requested change from the policyholder in writing). The following list includes but is not limited to the types of policy changes made effective by the rider:

a. Changing the effective date.

b. Changing the termination date.

c. Changing the benefits as requested by the policyholder.

d. Changing the definition of employee (full or part-time, active or retired, number of hours worked per week).

e. Changing from child ortho to adult and child ortho.

f. Changing the eligibility period.

g. Changing the Contribution requirements.

h. Adding a maximum on the number of deductibles that must be met by a family